# Healthcare Legal Alert: New York Department of Financial Services Makes Previous Health Care Insurer Guidance Mandatory

On April 22, 2020, the New York State Department of Financial Services ("DFS") issued Supplement No. 1 to Circular No. 8 (2020) which, in large measure, made mandatory softer guidance contained in the earlier Circular. Supplement No. 1 directs Issuers, including commercial insurers, managed care companies, prepaid health services plans, student health plans, municipal cooperatives and other entities that review and reimburse (or arrange for reimbursement of) claims for medical services to expeditiously resolve and pay hospital claims and assist participating hospitals with cash flow issues. DFS noted, "During this time of emergency, it is in the interest of all stakeholders to support hospitals, particularly community, rural and safety-net hospitals, to ensure that patients continue to get the care they need."

DFS noted that newly-enacted Insurance Law 4902(a)(13) and Public Health Law 4902(1)(k) prohibit Issuers from retrospectively denying claims for emergency department and inpatient services provided to COVID-19 patients on or after April 1, 2020 due to lack of medical necessity. Supplement No.1 contains the following claims-related directives:

- DFS has directed Issuers not to conduct retrospective reviews for any services provided at in-network hospitals until June 18, 2020 unless the Issuer has evidence that the hospital in question is engaging in fraudulent or abusive practices. Even in such cases, retrospective reviews and adjustments must be delayed until at least June 18, 2020.
- Issuers may confirm Member eligibility, coverage and cost-sharing, but must pay claims from in-network hospitals for inpatient and outpatient services that are otherwise eligible for payment without first reviewing such claims for medical necessity.
- DFS has directed Issuers to immediately pay (i) all undisputed outstanding claims for services rendered prior to March 7, 2020; and (ii) all claims for services rendered on or after March 7, 2020 through at least June 18, 2020.
- DFS has directed Issuers to quickly and efficiently resolve all disputed claims for services provided prior to March 7, 2020.
- Once retrospective reviews are resumed, Issuers must ensure that documentation requirements imposed on hospitals in the course of retrospective reviews are reasonable and take into consideration both the extraordinary circumstances of the public health emergency, and the relaxed documentation rules the Department of Health authorized during that period.
- DFS tolled until June 18, 2020 all time frames within which Issuers contractually require hospitals to submit internal and external appeals of denied claims.

DFS also imposed certain checks and balances on the hospitals that benefit from these new claim

payment mandates:

- DFS has indicated that hospitals should use reasonable best efforts to provide notice to Issuers within 48 hours of providing outpatient services that are typically subject to pre-authorization.
- In cases where Issuers have evidence of a hospital's fraudulent or abusive billing practices, DFS has extended mandatory retrospective review time frames to 90 days after retrospective reviews are once again permitted.
- To benefit from the streamlined payment mandate, hospitals must agree to not enforce any contractual limits related to an Issuer's ability to retrospectively review claims.

DFS noted that these changes do not apply to "non-essential elective procedures and non-urgent procedures" as defined in the Department of Health's COVID-19 Directive from March 23, 2020 (http://dmna.ny.gov/covid19/docs/all/DOH_COVID19_FacilityDirective_032320.pdf).

While DFS has no regulatory authority over self-funded or "TPA" product lines, it has encouraged Issuers to follow these directives for those products as well.

Finally, DFS directed Issuers to work with participating hospitals to provide financial assistance and cash flow support, including but not limited to implementing or increasing periodic lump sum payments if such support is financially feasible and prudent. While Issuers were directed to begin a process for developing such financial support plans, there has been no formal announcement from DFS regarding the status of those discussions and plans. On May 5, 2020, the Healthcare Association of New York State ("HANYS") advised its members that DFS requested that hospitals contact DFS directly to provide details as to their financial conditions and needs as part of DFS's efforts to work with Issuers to implement this final financial support directive. Hospitals were asked to contact John Powell, Director of Rate Review at the DFS Health Bureau at John.Powell@dfs.ny.gov

DFS's Supplement No. 1 to Insurance Circular Letter No. 8 (2020) is available here: https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2020_s01_cl2020_08

---

*Please visit our Healthcare Law Practice Area to learn more about the legal services we can provide in this area. If you have any questions or would like more information on the issues discussed in this communication, please contact any member of our Healthcare Law practice.*